Massage Intake Form

Personal Information

First Name	Last Name	Date of Birth	Gender

Address	City	State	Zip Code

Contact Number	Email

Emergency Contact

Full Name	Relationship	Contact Number

Full Name	Relationship	Contact Number

Medical Information

Please list any medical conditions or health problems you have had in the past or present:

Are you taking any medications? ☐ Yes ☐ No

If yes, please specify:

Do you suffer from chronic pain? ☐ Yes ☐ No

If yes, please explain: (including what makes it better or worse)

Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please list:

Massage Information

Have you had a professional massage before?

☐ Yes ☐ No

What type of massage are you seeking

☐ Relaxation ☐ Therapeutic/Deep Tissue ☐ Other: _____

Do you have any allergies or sensitivities? ☐ Yes ☐ No

If yes, please explain:

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

If yes, please explain:

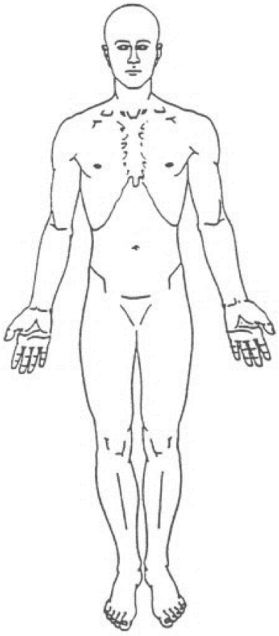
Personal Information

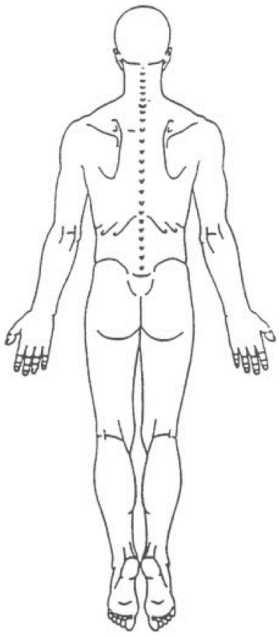
First Name	Last Name	Date of Birth	Gender

Massage Information (Continued)

What are your goal for this treatment session?

Please indicate or describe any area of discomfort:





- Adhesion
- Rotation
- Pain
- Tender Joint
- Hypertonicity
- Spasm
- Inflammation
- Trigger Point
- Elevation

Insurance

Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

Authorization

By signing below, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information change at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____